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# **Recovery in Psychiatry**

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## Introduction

In recent years, the concept of “recovery” from severe mental illness has increasingly gained relevance in the mental health field. Countries all over the world have been introducing recovery policy into mental health services (e.g. Australia, Ireland, New Zealand, United States), including England and Wales (Department of Health, 2001). However, there is still debate about the concept, such as whether symptom reduction is central (Liberman & Kopelowicz, 2005) or not (Roberts & Wolfson, 2004). This paper proposes a conceptual framework for recovery, and identifies emergent practical issues.

## One term – two meanings

Two classes of definitions can be identified for the term “recovery” in mental health, which emerged from two different influences. In psychiatry the idea of recovery is based on longitudinal studies demonstrating a widely heterogeneous course for severe mental illnesses (Davidson et al, 2005a). In this context, “remission” is defined as an improvement in symptoms and other deficits to a degree they would be considered within a normal range. “Recovery” can be seen as a long-term goal of remission. (Andreasen et al, 2005). We call this the **service-based definition** of recovery.

A second source of the term recovery was the self-help and consumer / user / survivor movement. Here, recovery may include but does not require symptom remission or a return to normal functioning. It is seen as a process of personal growth and development and involves overcoming the effects of being a mental health patient, with all its implications, to regain control and establish a personally fulfilling, meaningful life (Davidson et al, 2005a). We call this the **user-based definition** of recovery. This is exemplified by the NIMHE definition of recovery as the “achievement of a personally acceptable quality of life” (NIMHE, 2004).

Some examples of prominent service-based and user-based definitions are presented in Table 1.

--- insert Table 1 about here ---

The service-based definition of recovery is most easily applicable to people who return to a premorbid state of health e.g. after a single episode of psychosis. Several other types of recovery - within the unifying framework of the user-based definition - may apply to people who suffer a prolonged course of illness. For example, recovery can be the process of overcoming a traumatic event, achieving and maintaining sobriety or deriving useful personal developments from apparently useless experiences, such as psychotic episodes (Davidson et al, 2005a; NIMHE, 2004).

The divergence of these two perspectives, however, has in practice led to a situation in which recovery can have a lot of different meanings for different people. Hence recovery orientation can arbitrarily be claimed to be applied to a range of services without any universally accepted criteria or guidelines

## Components of recovery

In contrast to the mostly clearly defined service-based recovery criteria, the user-based recovery approach is a lot more complex. From a narrative literature review of user-based recovery we identified conceptual works by Davidson and colleagues (2005a, 2005b), Andresen and colleagues (2003), and Jacobson & Greenley (2001). These were synthesised into an emergent framework identifying the key components of recovery, shown in Table 2.

--- insert Table 2 about here ---

## **Stages of recovery**

According to the user-based definition, individuals tend to go through phases in their recovery process in which they approach the tasks outlined in Table 2. Though named differently, the various outlines of recovery phases in the literature are largely consistent (e.g. NIMHE 2004, Andresen et al, 2003). NIMHE outlines four consecutive stages named “Dependent & Unaware”, “Dependent & Aware”, “Independent & Aware” and “Interdependent & Aware”.

The starting point is described as a state of dependency due to the experience of illness/distress, the impact of the mental health system, traumatic events and the disruption of the daily live and of relationships. This period of crisis is characterised by denial, confusion, hopelessness, identity confusion and self-protective withdrawal. The goal and final stage of the recovery process is a state of psychological wellbeing, defined as personal growth, self acceptance, autonomy, positive relationships, environmental mastery, and purpose in life. Characteristics of this stage are not necessarily the absence of symptoms, but the ability to manage the illness and live a fulfilling and meaningful life, show resilience in the face of setbacks, and have a positive attitude towards the future.

To proceed from the initial state of disruption towards wellbeing, the individual first has to become aware of their condition as well as of the fact that recovery is possible, and start to work on recovery. This early phase in the recovery process (“Dependent & Aware”) involves recognising one’s values, strengths and weaknesses, beginning to set goals, learning about mental illness and services available, acquiring recovery skills, and connecting with peers. The next stage (“Independent & Aware”) involves setting and working towards personally valued goals, taking responsibility for managing the illness and taking control of one’s life, developing increasing knowledge and skills and building and maintaining relationships. An important characteristic of this phase is the constant growth in resilience, which requires the opportunity to take risks (i.e. to try something new). This requirement is challenging for risk-averse mental health services.

The step from being overwhelmed or resigned to gaining awareness, hope and determination is frequently described as a turning point in an individual’s life which may be triggered by an event, a clinician, a role model or a significant other. It can also be a conscious decision arrived at after being ill for a long period of time (Andresen, 2003; Davidson et al, 2005b).

## Recovery orientation in service provision

Overall, two shortcomings in current practice are identified by proponents of recovery orientation in mental health services: (a) best available evidence is not followed and (b) there are limitations to the evidence base (Frese et al, 2001).

Those who focus on the needs of the most seriously disabled tend to demand evidence based interventions, since many service users do not have a full choice of treatments. For example, over-reliance on pharmacotherapy (ODPM, 2004) even for conditions where guidelines indicate psychological interventions should be the first-line treatment (NICE, 2004).

On the other hand, people who have recovered from mental health problems often report that very individual things helped them, things that may have never been scientifically investigated (Frese et al, 2001). They call for the implementation of user-based recovery orientation in mental health services. An understanding that the planning, arrangement and delivery of support should be determined by the needs of the service user has now received policy endorsement (Department of Health, 2004).

One step in this direction internationally is the current president's program of the World Psychiatric Association – "Psychiatry for the Person" – that considers "*the whole person within his/her context as the centre and goal of clinical care, health promotion and research*" (Mezzich, 2006). From this perspective, the primary aim of psychiatric care is to enable people to function within their individual social context, irrespective of their symptoms and to help them live a personally fulfilling and meaningful life, irrespective of their need to use professional help in times of crisis.

This perspective on recovery may be reminiscent of the concept of quality of life, which also took into account a whole range of aspects of daily life aiming to place the consumer at its centre. However, similar to the concept of recovery, there is still no single universally accepted definition of quality of life and the distinction, interplay and importance of subjective and objective factors remains debated. It has also been shown that subjective (or user-based) and objective (or service-based) appraisals of quality of life often bear little relation (Ruggeri et al, 2001). To some extent, similar tensions exist between the two classes of recovery definitions. The user-based concept of recovery, however, goes far beyond the concept of quality of life or a simple needs-based service approach. The individual consumer is not only placed at the centre of attention but actively encouraged to take the responsibility for his/her own life with the aim of true power sharing, consumer participation and a reduced dependence on services. Recovery oriented systems of mental health are supposed to flexibly adapt to the consumer's needs, focus on strength rather than on deficits or dysfunction, and include a wide range of alternative facilities, such as peer-run services or faith communities (NIMHE 2004). These ambitious aims, though national policy, are far from being realised in England to date and empirical research on the application of recovery oriented principles in service provision is largely lacking.

## What needs to change?

Adopting a recovery oriented approach may have profound implications for mental health services. The **goals** and aspired outcomes of mental health care have to be redefined to focus on the individual's life goals and respecting service users' right to

make individual decisions about all aspects of their recovery. It is now recognised in legislation that a person “*is not to be treated as unable to make a decision merely because he makes an unwise decision*” (Mental Capacity Act, 2005). Indeed, the evidence of equivalent rates of mental incapacity between psychiatric and non-psychiatric in-patients (Raymont et al, 2004) suggests that the traditional reservations of psychiatric services towards ceding decision-making power to service users because they lack ‘insight’ may not be empirically justified. A successful example of such shared decision making are joint crisis plans which realise advanced agreements and directives for mental health care that have long been advocated by user groups organisations (Henderson et al, 2004).

Equally the **values and attitudes** of staff may have to shift. Recovery orientation for staff may mean to redefine their roles from that of “outside experts” for people’s illnesses to that of companions and helpers on people’s paths of life, accepting equal partnerships with their clients. This shift in roles changes the balance of power, and may be challenging for staff. However, limited, mainly qualitative, research indicates that adapting such an individual and holistic approach may have a positive impact on the recovery process (Farkas, 2005).

NIMHE outlines a whole range of **working practices** for clinicians to support recovery. These include demonstrating hope and offering encouragement e.g. in supporting people to achieve their individual goals, providing comprehensive information on the illness and available treatments, making shared decisions with clients, engaging families, facilitating peer interaction, supporting social, cultural and spiritual activities etc.

In **service structures** recovery values may be reflected in the organisation, administration and staffing, for example in a mission statement identifying recovery outcomes, policy statements and guidelines providing recovery based principles for service delivery, quality assurance developed, implemented and monitored collaboratively with service users, as well as staff selection, training and supervision according to recovery values and with user involvement. Recovery oriented services ideally work in flexible networks, adjusting to the individual’s support needs and their personal resources in their environment (Farkas, 2005). The importance of user involvement, which is particularly emphasised in the user-based recovery approach, has been known and applied in other fields, such as management or information technology, since the 1980s. In the mental health field, however, both sound practical experience with and systematic empirical research on the value, practicability and the effects of user involvement remains limited to date.

Without doubt, implementing recovery orientation in service provision will be a challenging and time-consuming process, with respect to both practice and research. In mental health care practice, a first step may be the promotion of understanding of the concept and its implications among the stakeholders (NIMHE, 2004). Recovery orientation is intended to complement rather than replace existing roles, functions, therapeutic interventions and structures. The central implementation challenge may be moving beyond an oppositional user-professional discourse which emphasises mental health care shortcomings (and hence alienates mental health staff) towards a value-adding discourse which harnesses the professional and personal qualities of staff. Such a partnership model of change will be difficult. Service users activists, who have previously defined their role by opposing a “biomedical model”, will be asked to

shift towards a collaborative approach in which their constructive input is needed by mental health services to develop practice change. In addition, giving power to “experts by experience” may not be a welcome development for some service users. For staff, the central challenges may be in meeting demands to change practice, to be less in a formal professional role when working with distressed (and distressing) individuals, to manage the anxiety involved in supporting the person to take chances, and in not imposing their values and models on service users.

In addition, however, it may be detrimental to the evolving recovery movement if service developments are ahead of research. In order to guarantee that the recovery concept will outgrow its momentary fashion and acquire lasting importance for service delivery a firm evidence base needs to be created on the distinct components of recovery orientation within mental health services, their acceptability, applicability and effects. Some important groundwork has already been laid. There is a wealth of qualitative research, several attempts to systematise the concept, and some newly developed measurement tools, such as the Stages of Recovery Instrument (STORI, Andresen R. et al, 2006) the Recovery Process Inventory (RPI, Jerrell J.M. et al, 2006) or the Recovery Assessment Scale (RAS, Corrigan P.W. et al, 2004). However, a lot of research, especially such using quantitative designs, still needs to be conducted to explore the challenges, possibilities and benefits this concept of recovery orientation can provide for both service users and staff.

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### **Declaration of interest**

None

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Table 1: Examples for the two classes of definitions for recovery

Service-based recovery definitions	User-based recovery definitions
For schizophrenia, over a period of at least two consecutive years: <ul style="list-style-type: none"> <li>• symptom remission (<math>\leq 4</math> on the positive and negative symptom items of the BPRS)</li> <li>• full- or part-time involvement in work or school</li> <li>• independent living without supervision by family or surrogate caregivers</li> <li>• not fully dependent on financial support from disability insurance</li> <li>• having friends with whom activities are shared on a regular basis<sup>1</sup></li> </ul>	Overcoming the effects of being a mental patient to retain or resume some degree of control over ones own life <sup>2</sup>
	The establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination <sup>3</sup>
	A process of personal discovery, of how to live (and how to live well) with enduring symptoms and vulnerabilities <sup>4</sup>
For schizophrenia: <ul style="list-style-type: none"> <li>• a reliable diagnosis of schizophrenia at an earlier time</li> <li>• criteria for diagnosis not fulfilled at present</li> <li>• out of hospital for at least 5 years</li> <li>• present psychosocial functioning within a 'normal range' (e.g. scores <math>&gt; 65</math> on the GAS)</li> <li>• not on neuroleptic drugs, or only on a low dosage (<math>&lt; 1/2</math> 'Defined Daily Doses')<sup>5</sup></li> </ul>	A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles <sup>6</sup>
	A way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness <sup>6</sup>
For eating disorders, over a period of at least 12 months no more than minimal symptoms: <ul style="list-style-type: none"> <li>• BMY <math>&gt; 19</math></li> <li>• no extreme fear to gain weight</li> <li>• no weight reduction by vomiting or laxative abuse</li> <li>• no binges</li> <li>• no preoccupation with figure<sup>7</sup></li> </ul>	The development of new meaning and purpose as one grows beyond the catastrophe of mental illness <sup>6</sup>

<sup>1</sup> Liberman et al, 2002

<sup>2</sup> Davidson, 2005a

<sup>3</sup> Andresen, 2003

<sup>4</sup> Roberts & Wolfson, 2004

<sup>5</sup> Torgalsb  en A.-K., 1999

<sup>6</sup> Anthony, 1993

<sup>7</sup> Kordy et al, 2002

**Table 2: User-identified key components of the recovery process**

<b>Hope</b> <p>Hope has been described as the individual's belief that recovery, or change, is possible, or as a determination to get better. Hope is a trigger of the recovery process and also maintains it.</p> <p>Hope involves</p> <ul style="list-style-type: none"><li>• Recognising and accepting that there is a problem</li><li>• Committing to change</li><li>• Reordering priorities</li><li>• Focussing on strengths rather than weaknesses</li><li>• Looking forward and cultivating optimism</li><li>• Believing in the self</li></ul>
<b>Spirituality</b> <p>Spirituality is an important source of hope and meaning when redefining one's life after the catastrophic event that severe mental illness may mean for an individual.</p>
<b>Responsibility &amp; control</b> <p>Re-assuming responsibility and control over one's life, illness and recovery can be seen as an act of emancipation in a system fostering dependency. It involves gaining back a sense of independence and is strongly linked to most other domains, especially the concept of empowerment.</p>
<b>Empowerment</b> <p>Empowerment can be seen as a corrective for the lack of control, the sense of helplessness and dependency that many consumers of mental health services develop over time.</p> <p>Empowerment involves</p> <ul style="list-style-type: none"><li>• Autonomy, which in turn depends on knowledge, self-confidence and the availability of meaningful choices</li><li>• Courage, which involves the willingness to step out of the safe routine and to take risks</li><li>• Assuming control and personal responsibility</li><li>• Demanding the same rights and taking the same responsibilities as other citizens</li></ul>
<b>Connection</b> <p>This element stresses the highly social aspect of recovery - the path from being isolated in one's illness to rejoining the social world. It involves establishing and maintaining relationships, assuming social roles and having friends.</p>
<b>Purpose</b> <p>To have meaning and purpose in life is a basic human need. Due to the experience of the illness, previous life goals may no longer be available to an individual, who then has to reassess their values and goals and to find alternatives. Associated tasks involve finding and moving into meaningful roles, working and enjoying recreational activities.</p>

**Self identity**

The re-conceptualisation of the self in the face of the overwhelming experience of severe mental illness is an important element in the recovery process

Redefining the self involves

- Accepting the illness
- Developing an explanatory framework to understand the experience
- Grieving what has been lost and understanding what has happened
- Defining the self apart from the illness, the illness as only a part of the self
- Re-establishing a sense of identity
- Developing self-esteem and self-respect

**Symptom management**

Although complete symptom remission is not necessary, the ability to manage symptoms in some way is essential. There may be periods when symptoms may be more or less under control, but overall, a shift occurs from simply receiving services to actively participating in and using treatments of one's own choice. The power to define the importance of symptom control is shifted to the service users, who may e.g. decide to rather live with increased symptom levels than with medication or its side effects.

Managing symptoms involves

- Knowing the illness and knowing available services
- Developing coping skills and illness management strategies
- Medication
- Fostering wellness and finding a healthy lifestyle

**Stigma**

Overcoming the social consequences of being a mental health patient has been described as a second healing process. It is an active process strongly linked with redefining the self and becoming empowered.